Inpatient Admission Versus Outpatient Observation Following an Outpatient Procedure

TrailBlazer[SM], the A/B Medicare Administrative Contractor (MAC) for Jurisdiction 4 (J4), has recently reviewed a targeted sample of 250 claims submitted on Type of Bill (TOB) 11X with Diagnosis-Related Group (DRG) 247 during the period of January–September 2008. The purpose of this medical review was to evaluate services billed as part of the Inpatient Prospective Payment System (IPPS) Pilot. Medical Review Part A performed complex medical reviews and made determinations based on Medicare reimbursement requirements pursuant to the provisions of the Social Security Act, Sections 1862 (a)(1), 1979 and 1870. The audit focused on:

- Verification of Medicare coverage for billed services.
- Determination of medical necessity.
- Determination of appropriateness of care setting.
- Appropriateness of procedure reviews (if applicable).
- Validation of the DRG.
- Determination of limitation on liability decisions.

The results are shared with the provider community in an effort to provide education, increase awareness, decrease billing errors and reduce vulnerabilities to the Medicare Trust Fund. An error rate of 98.8 percent was found in this review.

The Progressive Correction Action (PCA) error rate is calculated by the following formula:

$$\frac{\text{Dollar amount of services paid in error, as determined by Medical Review}}{\text{Dollar amount of services medically reviewed}}$$

Based on the results of the targeted review, the following problem areas were identified:

- Routine inpatient admission following a postoperative outpatient procedure for clinically stable patients. Documentation did not support the medical necessity of an inpatient level of care. Patients were admitted without documentation that clinical complications were present on admission. The care rendered was observation in most cases.
- Confusion on how to bill the outpatient service as observation instead of inpatient services.

Medical Review denied 98.8 percent of the claims reviewed in the sample. The reasons and percentages of denials are listed below:

Reason	Percentage of Denial
Medical record did not support inpatient level of care	87 percent
Incomplete or no documentation received	11 percent
Provider adjusted claim as non-covered charges	2 percent

The CMS *Medicare Benefit Policy Manual*, Chapter 1, "Inpatient Hospital Services Covered Under Part A," indicates the following:

"The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark, i.e., **they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis.** However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting."

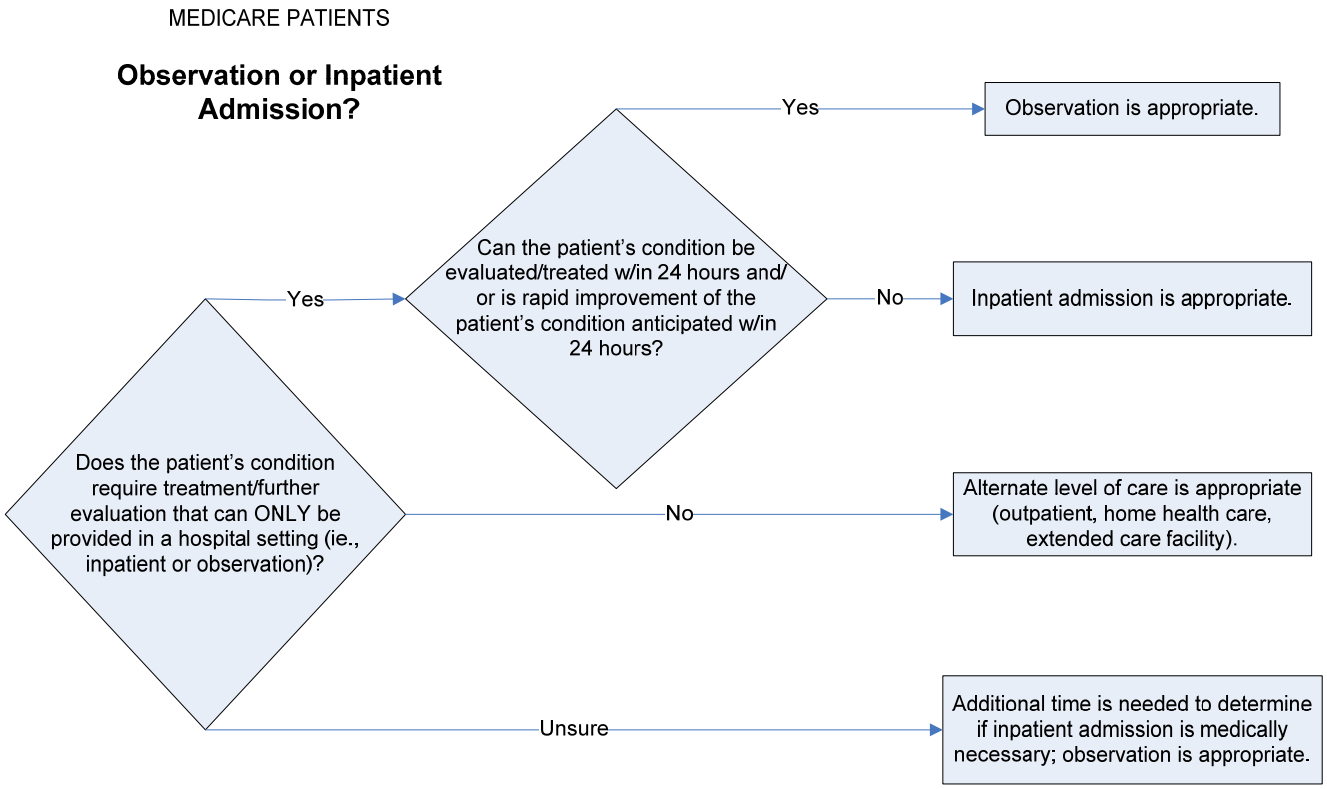
Providers may identify factors to be considered when making the decision to admit in the CMS *Medicare Benefit Policy Manual* available on the CMS Manuals Web page at:

http://www.cms.hhs.gov/Manuals/IOM/list.asp

TrailBlazer would like to reiterate the following information shared with the provider community regarding inpatient versus outpatient services:

- Outpatient observation is still an alternative to inpatient admission.
- An order simply documented as "admit" will be treated as an inpatient admission. A clearly worded order such as "inpatient admission" or "place patient in outpatient observation" will ensure appropriate patient care and prevent hospital billing errors.
- Medicare coverage for observation services is limited to no more than 48 hours unless the A/B MAC grants an exception.
- An outpatient observation patient may be progressed to inpatient status when it is determined the patient's condition requires an inpatient level of care.
- An inpatient admission cannot be converted to outpatient observation.
- Documentation must support the level of care provided (inpatient admission versus outpatient observation).
- Ensure the documentation addresses problems identified in the history and physical, treatment initiated, patient's response to treatment, major changes in the patient's

condition and action taken, status of unresolved problems, discharge planning and follow-up.



TrailBlazer encourages providers to use all available resources to understand and adhere to Medicare guidelines regarding coverage and documentation requirements associated with services provided. Resources are available on the CMS Web site at:

http://www.cms.hhs.gov/

Providers may find additional information and guidelines in the following CMS manuals:

- CMS *Benefit Policy Manual*, Chapter 1:

  http://www.cms.hhs.gov/manuals/Downloads/bp102c01.pdf

- CMS *Program Integrity Manual,* Chapter 6, Section 6.5:

  http://www.cms.hhs.gov/manuals/downloads/pim83c06.pdf